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The concentration of dental health services in urban areas creates a problem for the rural population of America. The problem is analyzed in this document by looking at the population distribution today and the ratio of dental services per population, the location of dental education resources, and the concern of society for the quality of living. Five objectives regarding dental health needs are discussed. Resources are identified which can help meet the objectives. It is concluded that the need for dental health is a national problem that can be solved if all facets of public health services work cooperatively toward a quality life for all. (DB)

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E.R.I.C.

"DENTAL HEALTH IN RURAL AREAS"*

Charles S. Howell, D.D.S.

Let me begin by saying that it is a pleasure to have the opportunity to speak before this group not only because rural dental health has been an area of personal interest and particular concern to me for many years, but also because dental care in rural areas has been officially recognized as a problem by the Council on Dental Health of the American Dental Association. On January 21, 1966, the Council issued a statement defining the problem, and calling for its solution through cooperative action by dental schools, constituent dental societies, and state health departments.

In addition, I am distinctly aware of the array of talent which is represented at this meeting and I am hopeful that presentations by dentists may stimulate further development of mutual, coordinated attacks on the problems we face in the rural health area.

Today in dentistry, as in other fields, there is a great deal of talk, concern, and activity with regard to urban health. This, of course, is as it should be for the problems of comprehensive, total health in metropolitan areas are acute. When one realizes that since this nation began the migration of people in this country has been into the metropolitan areas and we have shifted from 95 percent rural

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and 5 percent urban in 1790 to only 30 percent rural and 70 percent urban, the logical question could follow, "Why concern ourselves with problems of rural areas?" Perhaps my own rural background introduces an element of bias here, but I believe economists and sociologists would agree that the rural component of this country has significant meaning not only to our economic stability and well-being, but also to our social institutions.

Medical care in the past has concerned itself with death. Society today is saying in very clear tones that health care must devote itself not merely to death but the quality of living. Dentistry until recent years was regarded by most people as either an emergency or a luxury service and therefore was seen as optional. Today our society is saying that dental health is a vital part of total or comprehensive health. The dental profession has long supported that thesis.

Utilization of professional dental services has always been related to socio-economic factors, to the educational level of the head of the household, and to place of residence -- urban or rural. For example, over 75% of families with an annual income of $12,000 or more visit their family dentist annually, whereas only 12% of families whose income is $5,000 or less visit a dentist in a given year. Also, the utilization rate of all income groups except the very highest ones is essentially about half for rural families as compared with urban families.

If our ultimate objective is to promote total health rather than merely cure illness and prevent death, then the goal of health service

is in partnership to search for means of attaining quality and richness in human life. Dental care then becomes more important because the implications of optimum dental health are not only to the physical well-being but to the social adjustment and psychological happiness of the individual. To me the dental health needs of rural America are real, and they lend themselves to both individual efforts and to collective or community attention.

In order to understand the causes and seriousness of this situation we need to disentangle several strands which make up the nature of the problem. The first of these is the character of dental disease itself. Dental caries are cumulative so that conditions which are not prevented or treated do not return to a healthy state by natural processes. Similarly, periodontal disease, which represents the outstanding cause of tooth loss after young adulthood, is exacerbated as a result of non-treatment and poor or non-existent preventive therapy.

At the same time the costs of restorative dentistry are much higher than those of prevention and the numbers and educational level of health personnel required to treat acute forms of dental diseases greatly exceed the numbers and educational level of those who can maintain preventive health programs with patients. Thus the urban-rural differential in frequency of visits has serious economic and man-power consequences as well as direct implications for the health of the rural population.

There is another dimension that one must also consider and that is manpower resources. It is a fact that our health professionals are

concentrated primarily in the urban centers where they receive their education. On a national basis there is one dentist for approximately every 2,000 population or 50 dentists per 100,000 population. Yet there are only 13 states, plus the District of Columbia, that have 50 dentists per 100,000 population which means there are 37 states with less than 50 per 100,000. In fact, there are 12 states with but 33 or less per 100,000. That is to say that approximately one fourth of our states have a ratio of dentists to population of 1 to 3,000 or 50% less fortunate than the national average.

Another interesting phenomenon is the distribution of dental education resources. Statistics reveal that the nation's dental schools with students, numbering 48, are located in states whose population is primarily urban in character. These represent 30 states. The remaining 20 are primarily rural in character and are, in essence, dependent on those states supporting dental education. Now, phase into this picture the land-grant college situation, particularily those states that are primarily rural in character. Of the land-grant colleges only 13 have dental schools and four of these - Connecticut, Kentucky, University of Missouri-Kansas City and West Virginia are of recent vintage. Only 23 have medical schools.

This analysis leads to the following objectives in regard to rural dental health needs and identification of resources as possible solutions for meeting the needs:

1. Identification of the problem and the resources

This may be done on either a state-wide or regional basis. Your local and state dental societies currently have committees directing their attention to these problems. Your official health agencies both at the local and especially at the state level have not only responsibility but capabilities and know-how in this regard.

2. Manpower resources

I wish to give this area special attention because there are resources already available to you that you may or may not be using. Hill-Burton facilities under the Hospital Survey and Construction Act urged the inclusion of dental facilities in most of your community hospitals. Do you have these facilities? Are dentists using them? Have you ever attempted to "recruit" a dentist to your community by offering him these facilities?

What is going on in your area under the Regional Medical Program? Are your dental health needs and your overall interests being adequately represented in the program planning phase of this program which was intended to benefit you? Or what about the Area Comprehensive Health Care Planning under the Partnership for Health Legislation? Are rural intersts for health in general, or in this case dental health, being adequately represented and heard?

3. Individual responsibility

This deserves very special attention -- although possibly it does not require so much emphasis to a group representing rural America, for rugged individualism has long been one of the salient

characteristics of rural people. But there are preventive dental health measures available to the individual such as proper diet, nutrition, and oral hygiene. There are also preventive measures such as fluoridation and others that dental science is developing that require collective action. But individuals provide the leadership that culminates in group action. It is individual action that will insure maximum use of other resources from the Federal, state, and local levels. One of the great rewards of my life was my experience twenty plus years ago working with the 4-H Club members and their leaders in developing the Health Unit of the 4-H's.

4. Allied health professions

Much can and must be done in identifying the scope of the roles, the requisite education, and the state statutes applying to functionally useful allied health personnel. The need for action here cuts across all elements of our society - the professions, education at all levels, especially community or junior colleges, and state legislatures which must work together to implement the plans.

5. Land-grant colleges - a new dimension

The Morrill Act establishing the land-grant colleges to sustain and enrich the social economy of our country was the Federal government's first venture into higher education. History records, and I have seen firsthand, the many contributions of the Cooperative Extension Services of these colleges. I ask: should not, must not these colleges with the many resources inherent and available to them direct

their attention to the health needs of rural America? To me, this provides new doors and opens many others, in the role of leadership and coordination in education and even direct services in partnership with the professions, and official and voluntary health agencies.

As I conclude, some of you may think I am dreaming, some of you may think I am an idealist but these goals are possible if we want not merely to provide medical care but if we seek to enhance quality and richness of life throughout this nation. Think of Apollo 8! To perform that great feat was very costly in creativity,determination, and dollars. But hard science said "this is what we need to do, this is what we can do, and this is what it will cost." They did it and it did cost.

We can define the dental health needs of the nation, we can project the manpower needs and therefore the costs, whatever may be the sources of support. I would be the first to admit that because of the human element we do not have all of the answers. But I would like to be among those who say we cannot wait for all of the answers, that we must get on with the business at hand. Dental health is a vital part of total health and all of us must proceed in a true partnership to fulfill our individual responsibilities and provide quality of life for all.

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